



Published by
Health Services Analysis Section
Olympia, WA 98504-4322

PROVIDER BULLETIN

PB 00-08

THIS ISSUE

Utilization Review Program

TO:

Medical Physicians
Osteopathic Physicians
Podiatric Physicians
Nurses & Nurse Practitioners
Physician Assistants
Clinics
Chiropractic Physicians
Naturopathic Physicians
Surgery Centers
Urgent Care Centers
Free Standing Emergency
Care Centers
Third Party Administrators
Hospitals:

Please route to:

Utilization Review
Quality Assurance
Medical Records
Patient Accounts
Internal Auditing
Admitting
Case Management
Social Services

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Table of Contents

Purpose

Table 1. Provider Bulletins this Issue Replaces

Program Description

Definitions

Prospective Review
Concurrent Review
Retrospective Review
Re-Review
Level One Peer Review
Level Two Peer Review
Protest, Reconsideration, and Appeal
Pre-certification Number / Notification Number / Prior Authorization Number

Services that require Utilization Review

Inpatient
Outpatient
Table 2. List of Outpatient Procedures Requiring UR

MRIs no longer require UR or Prior Authorization

What Providers and Staff need to know about the UR Process

Who to Contact for Questions about the Program, Contract, or Process
Who to Contact for Questions about Specific Claims or Reviews
How the UR Process Works

Step by Step Instructions on How to submit a Request for Review

WACs and RCWs

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Purpose

The purpose of this Provider Bulletin is to provide you with a single comprehensive source of information about Labor and Industries' Contracted Utilization Review (UR) program. This bulletin applies to State Fund claims only and does NOT apply to self-insured employers and their representatives or administrators. This bulletin updates and consolidates information that has been published in several previous Provider Bulletins.

Although medical treatment guidelines were published in earlier bulletins and many remain in effect, they are NOT repeated here because they are available in a single published document and on the Internet. You can obtain a complete set of L&I's Medical Treatment Guidelines by telephoning the Office of the Medical Director (OMD) Publications line at (360) 902-5026 or by going to the OMD Internet site: <http://omd.inside.lni.wa.gov/polframeset.htm>.

Information in this Provider Bulletin is effective immediately unless otherwise noted. This bulletin replaces those Provider Bulletins (PB) and Provider Updates (PU) listed below.

Table 1. Provider Bulletins this Issue Replaces

Bulletin/Update Number	Date Issued or Revised	Title
PB 88-09	7/88 and 2/98	Inpatient Utilization Review Program
PB 89-09	9/89	Modifications to the Inpatient Bill Audit Program
PB 91-03	5/91	Inpatient Screening Criteria for Entrapment of a Single Cervical Spinal Nerve
PB 92-01	3/92 and 2/98	Surgical Criteria for Inpatient Surgery
PB 94-07	1/94	Outpatient Program Development and Surgical Diagnostic Criteria
PB 94-10	2/94	Introducing Outpatient Program and Targeted Procedures
PU Vol. 1, No. 3	7/94	Outpatient Utilization Review Program
PB 96-03	3/96	Outpatient Utilization Review Program Change in Herniorraphy Authorization
PB 98-05	6/98	Utilization Management Criteria for Medical Back Admission and Lumbar Fusion
PB 99-07	7/99	New Utilization Review (UR) Firm; New UR Contract Manager; New UR Program Management

Program Description

The department's contracted UR program began on July 18, 1988. The program only applies to claims that are adjudicated by the State Fund. The UR program applies to both physicians and facilities. The department defines UR as the process of comparing requests for medical services ("utilization") to treatment guidelines that are deemed appropriate for such services, and includes the preparation of a recommendation based on that comparison. OMD manages the contract with the department's UR vendor, and monitors the quality of reviews by the UR vendor and the department's in-house medical consultants. The goal of the UR program is to support the agency's mission to purchase only proper and necessary care for injured workers.

The department contracts with Crawford & Company (Crawford) in Atlanta, Georgia to provide utilization review services. Reviews are initially conducted by Crawford staff nurses, and may go on to their medical director for further review, or on to other Washington State licensed physicians for a peer matched review.

The department requires Crawford to review all the outpatient procedures listed in Table 2 of this bulletin. The department also requires Crawford to review all inpatient hospital stays except: 1) treatment by contracted pain programs, 2) chemical dependency treatment, 3) head injury care after the acute injury and treatment phase, or 4) care in a skilled nursing facility, transitional care unit, or step down unit. The department reviews these conditions internally for proper and necessary care.

Crawford reviewers make recommendations only. They never authorize or deny a procedure or service. This is the sole responsibility of the department's claim manager.

Definitions

Prospective Review

Prospective reviews are those that are conducted prior to the delivery of the services for which payment has been requested. Prospective reviews may be for inpatient or outpatient procedures or services. The term "prospective review" is synonymous with "pre-certification."

Concurrent Review

Concurrent reviews are those that are performed while the worker is still an inpatient and services are being provided. Concurrent reviews can occur in one of three ways: 1) The timing of a review is planned to cover services as they are being provided (e.g. the need to extend a current hospitalization); or 2) During an emergency admission when a prospective review is not possible; or 3) When a provider or facility notifies the department of an admission for a non-emergent procedure and a prospective review was not performed.

Retrospective Review

Retrospective reviews are those that are performed after the requested service or procedure has already occurred and the patient has been discharged. For example, a retrospective review would be required for an inpatient admission if no prospective review had been done before the admission.

Re-Review

A re-review occurs when a provider or claim manager requests that Crawford take another look at their initial recommendation on a claim. The provider submits NEW information that has a bearing on this request to Crawford's Medical Director.

Level One Peer Review

A peer review level one is initiated when a provider or claim manager requests that Crawford take another look at their recommendation and NO NEW information is submitted. If no new information is submitted with the request, Crawford will refer the request to a peer-matched health care provider who is both licensed to practice and who physically resides in the state of Washington.

Level Two Peer Review

A level two peer review is initiated when the provider or claim manager requests that the recommendation be reviewed again, after a level one peer review has been done. The request for a level two peer review requires the approval of the department's associate medical director for UR. In this case, the review is performed by three specialty-matched providers who are both licensed to practice and who physically reside in the state of Washington. The department's medical director or designee may also request a level two peer review.

Protest, Reconsideration, and Appeal

When the claim manager decides to authorize or deny an inpatient admission or treatment, he or she will inform the provider of that decision by letter. The letter will include instructions about the provider's options to submit a protest or request for reconsideration to the department or to the Board of Industrial Insurance Appeals. The provider then has 60 days after receipt of the claim manager's letter to request in writing that the decision be reconsidered. If the provider wishes to protest the department's reconsideration decision the provider has another 60 days after receipt of that decision to appeal to the Board of Industrial Insurance appeals at 2430 Chandler Ct. S.W. Olympia, WA 98504-2401. If you have questions about this process, please contact your claim manager.

Pre-certification Number / Notification Number / Prior Authorization Number

These terms are often used interchangeably by different business groups. At L&I, they all refer to the 10 digit number that is issued by the UR vendor for each review they perform. The number is sometimes referred to as a "pre-certification number" by the vendor; a "notification number" by providers, and a "prior authorization number" if the claim manager authorizes or denies a procedure. Hospitals may use the term "reference number." These terms are all synonymous.

Please Note: Having a PA number assigned to your request does not guarantee the procedure or treatment will be authorized. Lack of a PA number on your bill may cause it to deny. Including the PA number on bills submitted to the department expedites their processing. Knowing the PA number will help you when inquiring about the status of the request. The PA number is used to track hospital and physician bills that are associated with a request. It can also be used to access information in the claim file.

Services that require Utilization Review

Inpatient

All inpatient hospitalizations require utilization review by Crawford. However, providers should not delay surgical intervention if delay will compromise a worker's health, safety or chance for a good surgical outcome. In the event of an emergency admission, providers should telephone Crawford within 24 hours or on the first working day following admission.

Outpatient

The department does not require utilization review on all outpatient procedures. Only the procedures listed in Table 2 require review.

Table 2. List of Outpatient Procedures Requiring UR

DIAGNOSTIC ARTHROSCOPIES		
	CPT Procedure Codes (Non-Hospital Provider)	ICD.9 Surgical Procedure Codes (Hospital Provider)
Diagnostic arthroscopy of shoulder	29815	80.21
Diagnostic arthroscopy of elbow	29830	80.22
Diagnostic arthroscopy of wrist	29840	80.23
Diagnostic arthroscopy of knee	29870	80.26
Unlisted procedure arthroscopy	29909	80.20
SURGICAL ARTHROSCOPIES		
	CPT Procedure Codes (Non-Hospital Provider)	ICD.9 Surgical procedure Codes (Hospital Provider)
Shoulder	29819, 29820, 29821 29822, 29823, 29825 29826	80.21
Knee	29871, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889	80.26
SHOULDER SURGERIES		
	CPT Procedure Codes (Non-Hospital Provider)	ICD.9 Surgical procedure Codes (Hospital Provider)
Arthrotomies	23101, 23105 23106, 23107	80.11
Claviclectomies	23120, 23125 (partial/total)	77.81 77.91
Acromioplasty	23130	81.81 81.82 81.83
Ostectomy of the scapula	23190	77.81 (partial) 77.91 (total)
Rotator cuff repair	23410, 23412 (acute/chronic)	83.63
Repair of shoulder	23420	83.63
Coracoacromial ligament release	23415	83.63
Biceps tendon repair	23430	83.88

Biceps tendon resection	23440	83.42
Repair shoulder capsule	23450, 23460 23462, 23466	81.82 81.93
Bankart shoulder repair	23455	81.82
Rib Resection for TOS	21600, 21615	77.81, 77.91
Unlisted procedure, shoulder	23929	81.83
NEUROPLASTIES		
	CPT Procedure Codes (Non-Hospital Provider)	ICD.9 Surgical procedure Codes (Hospital Provider)
Revise ulnar nerve at elbow	64718	04.6 (transposition) 04.49 (release)
Revise ulnar nerve at wrist	64719	04.49
Carpal tunnel surgery	64721	04.43
Wrist endoscopy or surgery	29848	80.23
SPINE SURGERIES		
	CPT Procedure Codes (Non-Hospital Provider)	ICD.9 Surgical procedure Codes (Hospital Provider)
Laminectomies/ Diskectomies	63001-63308	03.01, 03.02 03.09, 80.50 80.51, 80.59
Arthrodesis of spine	22548-22819	81.00, 81.01 81.02, 81.04 81.06
Exploration and Instrumentation	22830-22855	03.02, 81.05 78.69

MRIs no longer require UR or Prior Authorization

MRIs performed on or after January 15, 2000 do not require utilization review or prior authorization. This effective date is intentionally retroactive. Providers no longer need to notify Crawford when requesting MRIs, and the claim manager no longer needs to give prior authorization for routine requests. Although prior authorization has been eliminated, all treatment is required to be proper, medically necessary and related to the industrial injury. The claim manager still has the prerogative to request that an MRI, for any date of service, be reviewed retrospectively if he or she has reason to believe the procedure was not proper and necessary based to the accepted condition(s) on the claim.

The department will periodically monitor utilization of MRIs and evaluate whether they should continue to be exempt from UR and the prior authorization requirements.

What Providers and Staff need to know about the UR Process

Who to Contact for Questions about the Program, Contract, or Process

At Labor & Industries:

Associate Medical Director in charge of UR	Lee Glass MD	360-902-4256
Contract Manager	Nikki D'Urso	360-902-5034
Quality Assurance Manager	Simone Stilson	360-602-6319
Address for all names listed above: PO Box 44321 Olympia, WA 98504-4321		

At Crawford & Company:

UR Branch Manager	Jan Wilbanks RN	800-541-2894, ext. 21952		
Crawford Medical Director	Greg Smith MD	800-541-2894 ext. 21954		
<table><tr><td>By Postal Service: Crawford & Company Utilization Management Services 64 Perimeter Center East, Suite 800 Atlanta, GA 30346</td><td>By Phone or Fax: Phone: 800-541-2894 Fax: 877-657-2547 (toll free)</td></tr></table>			By Postal Service: Crawford & Company Utilization Management Services 64 Perimeter Center East, Suite 800 Atlanta, GA 30346	By Phone or Fax: Phone: 800-541-2894 Fax: 877-657-2547 (toll free)
By Postal Service: Crawford & Company Utilization Management Services 64 Perimeter Center East, Suite 800 Atlanta, GA 30346	By Phone or Fax: Phone: 800-541-2894 Fax: 877-657-2547 (toll free)			

Who to Contact for Questions about Specific Claims or Reviews

Providers can call the department's Interactive Voice Response (IVR) system at 1-800-831-5227 between the hours of 6:00am and 7:00pm weekdays, to obtain automated information regarding the status of a claim, authorized medical procedures, allowed diagnosis, a claim manager's name and phone number, and other claim specific information. For personal assistance, providers may contact the Provider Hotline at 800-848-0811 or the patient's claim manager.

How the UR Process Works

The department requires that physicians who wish to admit patients for inpatient hospital stays or who wish to perform selected outpatient procedures (see Table 2), request a review by Crawford and obtain a subsequent authorization or denial decision by the department's claim manager. On the occasions where a facility admits patients without a prior review or authorization (e.g. on an emergency basis), the facility should contact Crawford directly as soon as possible to initiate the review process.

Failure to comply with the UR process may result in delayed or denied payment. Each time Crawford makes a recommendation to the department, the claim manager will determine whether to authorize or deny it. If the CM authorizes the procedure, he or she enters the prior authorization number, the authorization status, and an authorized admission date span into the claimant's computerized records. Payment is contingent on the authorization status, date and code accuracy, and the injured worker's eligibility for coverage. This applies to both facility charges and professional charges that are associated with the given admission or procedure.

How to Request a Review

1. To request a review for an inpatient hospitalization or for an outpatient procedure that requires UR, contact Crawford via the toll-free phone **(800-541-2894)** or fax **(877-657-2547)** numbers.
2. Crawford review staff will be available by phone between the hours of 7:00 a.m. and 4:00 p.m., Pacific Standard Time. Anytime during non-business hours and weekends, providers can leave a phone or fax message requesting a review.
3. Please be prepared to supply relevant clinical information to Crawford with your request. This may include chart notes that document the patient's history, physical exam, diagnostic test results and the treatment plan. Refer to L&I's Medical Treatment Guidelines (mentioned under "**Purpose**") for information on what specific clinical information is required for selected procedures.
4. Step by step instructions on how to request a review are described at the end of this bulletin.

What Crawford does with the Requests

1. Once Crawford receives a request for a **prospective review** (see "Definitions" section) with all the necessary clinical information, they will assign it a "notification number" (same as department's PA number) and forward the case to their nurse for review. The nurse will compare the clinical information supplied by the requesting physician to either the department's treatment guidelines or InterQual criteria.
2. Crawford will perform a **concurrent review** (see "Definitions" section) if an authorized outpatient procedure extends into an inpatient stay. In these cases, the hospital or attending physician must notify Crawford of the change in status so they can review the stay for the appropriate level of care.
3. Crawford will perform a **retrospective review** (see "Definitions" section) in the same manner as a prospective review, only the patient will have already been discharged when the review begins.
4. Crawford will notify the provider when they have completed a review. They will also inform the provider of the PA number and who to contact at the department for authorization.
5. If the clinical information supplied with the request does not meet the guidelines and/or criteria, the Crawford review nurse will refer the request to a Crawford medical director for review. The medical director may call the requesting physician to discuss the request or to obtain additional information. Based on available information, the medical director will make a recommendation to the claim manager.
6. The claim manager will review the information and recommendation made by Crawford and will then decide whether to authorize or deny the request. **The claim manager makes the final decision and is responsible for communicating that decision to the requesting provider.**

What to do if your Patient's Claim has not been Initiated

A claim is considered to be “uninitiated” when the department has not received a completed and signed Report of Accident. RCW 51.48.060 requires physicians to file a report of accident with the department with five days of the treatment date. Reports of Accident may be faxed to the department at 360-902-4980.

Crawford will review requests for treatment or procedures on uninitiated claims in the same manner as initiated claims. Physicians and facilities should follow the same UR procedure, but department authorization will be delayed until the claim has been initiated and assigned to a claim manager. Decisions for medical care should be based on the providers’ best clinical judgment and not on the status of the request.

What to do if you have Additions or Changes to the CPT codes or Dates of Service on the Original Request

Please contact Crawford by phone or fax as soon as possible if there are changes to the CPT codes or dates of service on the original request. If the request is for a CPT code change and the surgery has already occurred, please include a copy of the operative report. Please be aware that payment of your bill can be delayed if it has missing or inaccurate CPT codes or dates of service.

What to do if you are not satisfied with the Outcome of your Request

First, identify *which* outcome you are not satisfied with:

- a) If you are not satisfied with the outcome of Crawford’s recommendation, you can request directly from Crawford that they re-review their recommendation. Refer to the “**Definitions**” section above to determine what level of review to request. Be sure to include any new or additional information that would support the need for the requested procedure or treatment.
- b) If you are not satisfied with the outcome of the claim manager’s decision, you can either request that the claim manager reconsider the decision, or you can file an appeal directly with the Board of Industrial Insurance Appeals. Refer to either the “**Protest, Reconsideration and Appeal**” section above, or Labor & Industries’ Attending Doctors’ Handbook for more information on the protest and appeals process. The Attending Doctors’ Handbook is available from your local Service Location or the department’s warehouse at:

Department of Labor & Industries Warehouse
PO Box 44843
Olympia, WA 98504-4843

If you want to check on the status of a review by Crawford, please allow at least five business days from the date you initiated your request before contacting the department (except for emergencies). If the department has not received Crawford's recommendation, staff will not have the information.

Step by Step Instructions on How to submit a Request for review

Admitting physician or physician's staff:		<ol style="list-style-type: none"> 1. Calls or faxes the request to Crawford five or more calendar days before a planned elective admission or within 24 hours of an emergent admission. 2. Provides the following information to Crawford: <ul style="list-style-type: none"> • Claimant (patient) name • L&I claim number • Proposed or actual admission date • ICD-9-CM admitting diagnosis(es) • CPT codes for planned procedure(s) • L&I Provider number • Convenient time for the Crawford nurse or medical director to call the physician back.
Crawford intake staff:		<ol style="list-style-type: none"> 3. Documents the information from the physician's office, assigns a notification number, and gives the information to a nurse to begin the review.
Crawford nurse:		<ol style="list-style-type: none"> 4. Compares documentation to L&I's medical treatment guidelines and/or InterQual criteria 5. Evaluates the requested length of stay 6. Verifies CPT and ICD-9 codes are appropriate 7. Compares requested procedure with the accepted condition(s) on the patient's claim 8. If necessary, refers request to Crawford's medical director or other appropriate physician reviewer 9. Informs physician's office when they have completed the review and have forwarded the recommendation to the department
Crawford medical director:		<ol style="list-style-type: none"> 10. If the review has been sent to Crawford's medical director, he/she may contact the requesting physician directly to discuss the proposed treatment plan
L&I claim manager:		<ol style="list-style-type: none"> 11. Reviews Crawford's recommendation and makes decision to authorize or deny the request 12. Communicates his/her decision to the requesting physician 13. Enters appropriate information into L&I's computer system to insure appropriate payment
Crawford nurse:		<ol style="list-style-type: none"> 14. For unscheduled inpatient admissions, Crawford will contact the physician to get the admission date. 15. For all inpatient admissions, verifies the admission and discharge dates, confirms actual procedure codes, and sends a final recommendation report to the claim manager

REQUEST FOR SURGERY FORM

INPATIENT / OUTPATIENT

(Please circle the appropriate one)



Patient Information

Name: _____ Claim #: _____

Date of Birth: _____ Date of Injury: _____ Social Security #: _____

Requesting Physician Information

Physician: _____ L&I Provider #: _____

Office Contact: _____

Office Phone #: _____ Office Fax #: _____

Best time for Crawford's medical director to contact the physician: _____

Procedure Information

Dates of Service: _____ Requested Length of Stay: _____

Facility Name: _____ L&I Provider #: _____

Facility Phone #: _____

ICD9-CM Diagnosis Code: _____ CPT Code(s): _____

Indications for Surgery

Chart notes attached: Y / N (Please circle one) Number of Pages: _____

Please fax this form to
Crawford & Company **(877) 657-2547** or mail to:
64 Perimeter Center East, Suite 800
Atlanta, Georgia 30346

WACs and RCWs

WAC 296-20-01002 Definitions (excerpt)

Proper and necessary:

- (1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.
- (2) Under the Industrial Insurance Act, “proper and necessary” refers to those health care services which are:
 - (a) Reflective of accepted standards of good practice, within the scope of practice of the provider’s license or certification;
 - (b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;
 - (c) Not delivered primarily for the convenience of the claimant, the claimant’s attending doctor, or any other provider; and
 - (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.
- (3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker’s condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker’s condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. “Maximum medical improvement” is equivalent to “fixed and stable.”
- (4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

WAC 296-20-024 Utilization management

The department, as a trustee of the medical aid fund, has a duty to supervise the provision of proper and necessary medical care that is delivered promptly, efficiently, and economically. Toward this end, the department will institute programs of utilization management. These programs are designed to monitor and control the proper and necessary use and cost of, health care services. These programs include, but are not limited to, managed care contracting, prior authorization for services, and alternative reimbursement systems.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-024, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-024, filed 11/30/87, effective 1/1/88.]

WAC 296-20-075 Hospitalization

- (1) Hospitalization will be paid for proper and necessary medical treatment of the accepted condition(s). The department may develop and implement utilization management criteria which will be used to review inpatient hospital admissions. Reimbursement for hospitalization is limited to proper and necessary care for an accepted condition. Failure to comply with these criteria may result in delayed or reduced reimbursement to the provider as allowed under chapter 51.48 RCW. Ward or semi-private accommodations will be paid, unless the worker's condition requires special care.
- (2) Discharge from the hospital shall be at the earliest date possible consistent with proper health care. If transfer to a convalescent center or nursing home is indicated, prior arrangements should be made with

the department or self-insurer. See WAC 296-20-091 for further information. The department may designate those diagnostic and surgical procedures which will be reimbursed only if performed in an outpatient setting. When procedures so designated must be performed in an inpatient setting for reasons of medical necessity, prior authorization must be obtained.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-075, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-075, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-075, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-075, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-075, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-075, filed 6/1/71; Order 70-12, § 296-20-075, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-075, filed 11/27/68, effective 1/1/69.]